

EXHIBIT 13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396035	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/11/2023
NAME OF PROVIDER OR SUPPLIER: SCOTTDALE HEALTHCARE & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 900 PORTER AVENUE SCOTTDALE, PA 15683		
STATE LICENSE NUMBER: 232802				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
K 0000	<p>INITIAL COMMENT</p> <p>Facility ID# 232802</p> <p>Component 01</p> <p>Main Building</p> <p>Based on a Medicare/Medicaid Recertification Survey completed on December 11, 2023, it was determined that Scottdale Healthcare and Rehabilitation Center was not in compliance with the following requirements of the Life Safety Code for an existing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a). This is a one-story, Type V (000), unprotected wood frame building, without a basement, that is fully sprinklered.</p>	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396035	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/11/2023
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STATE LICENSE NUMBER: 232802				
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K 0321 SS=E	<p>Continued from page 2</p> <p>Based on observation and interview, it was determined the facility failed to maintain hazardous area enclosures in two instances, affecting one of two smoke compartments.</p> <p>Findings include:</p> <ul style="list-style-type: none"> 1. Observation on December 11, 2023, revealed the facility failed to maintain the required one-hour fire rating in the following hazardous area enclosure locations: <ul style="list-style-type: none"> a) 11:05 a.m., there was an unsealed duct work penetration in the ceiling of the laundry room above the dryers; b) 11:09 a.m., there was an unsealed wire penetration in the ceiling of the laundry room on the soiled linen side. <p>Interview with the Facility Administrator and the Maintenance Supervisor on December 11, 2023, at 12:30 p.m., confirmed the listed hazardous area</p>		K 0321	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 2/17/2024

FORM APPROVED

2567-L

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396035	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/11/2023
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K 0321 SS=E	Continued from page 3 enclosure deficiencies.	K 0321	(X5) COMPLETE DATE



Certified End Page

SCOTTDALE HEALTHCARE & REHABILITATION CENTER
STATE LICENSE NUMBER: 232802
SURVEY EXIT DATE: 12/11/2023

**I Certify This Document to be a True and Correct Statement of Deficiencies and
Approved Facility Plan of Correction for the Above-Identified Facility Survey**

A handwritten signature in black ink, appearing to read "Jeane Parisi".

Jeane Parisi
Deputy Secretary for Quality Assurance

A handwritten signature in black ink, appearing to read "Debra L. Bogen MD".

Debra L. Bogen, MD, FAAP
Acting Secretary of Health



THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY